Clear

SUPERVISOR MUST COMPLETE THIS FORM AND SEND IT TO THE SAFETY AND HEALTH OFFICE AFTER THE SIGNATURES ON THE REVERSE SIDE.

SUPERVISORY MISHAP REPORT

NOTE Read the Privacy Act Statement on reverse before completing this form.

1. MISHAP ID NO. (S&H Use Only)

2. MISHAP DATE (DD-MM-YYYY)

3. MISHAP TIME (Use Military Clock)

4. MISHAP ORGANIZATION (Organization reporting this mishap)

5. MISHAP LOCATION (Examples on reverse)

a. Primary:

b. Secondary:

6. MISHAP DESCRIPTION (Describe in detail what happened that caused the injury or illness and identify the source(s) of the injury, illness, property damage, and/or vehicle damage and identify the source(s) of the same (i.e. fell down ice covered steps; malfunction of the air conditioning unit led to extreme temperature in office; hit employee with lumber carried by forklift)). Use blank sheets of paper if more room is needed.

7. IF CONTRACTOR CAUSED MISHAP, PROVIDE CONTRACTOR'S COMPANY NAME:

8. MOTOR VEHICLE INFORMATION

a. Year	b. Make	c. Type (Car, motorcycle, etc.)	d. License Number/State

e. VIN

f. Estimated Cost of Vehicle Damage

9. ADDITIONAL VEHICLE INFORMATION

a. Year	b. Make	c. Type (Car, motorcycle, etc.)	d. License Number/State

e. VIN

f. Estimated Cost of Vehicle Damage

10. VALID EQUIPMENT LICENSE/PERMIT ☐ a. YES ☐ b. NO

11. SEAT BELT(S) IN USE ☐ a. YES ☐ b. NO

12. EQUIPMENT ID NO. (Any identifier such as model or serial number)

13. DESCRIPTION OF PROPERTY DAMAGED (i.e.10,000 lbs. forklift, perimeter fence)

14. EQUIPMENT/PROPERTY/MOTOR VEHICLE DAMAGE DESCRIPTION (i.e. dented left front fender, bent stop sign, broken CRT)

15. PROVIDE INFORMATION BELOW ABOUT EACH PERSON INVOLVED IN THE MISHAP AND/OR DAMAGE INCIDENT (PLEASE PRINT)

a. FIRST INDIVIDUAL - NAME

Employee Organization

Type (X one) ☐ Civilian Employee ☐ Foreign National ☐ Military

If Civilian Employee SSN:

CA 1 or CA 2 Filed ☐ Yes ☐ No

If Yes, Date (DD-MM-YYYY):

If Military Title

☐ On Duty ☐ Off Duty

If Foreign National ☐ Direct Hire ☐ Indirect Hire

Did inj/ill occur during Overtime? ☐ Yes ☐ No

Date Stopped Work or First Became Aware of Illness

Injury Case Classification (Check appropriate classification)

☐ Same Day Clinic visit or no treatment
☐ Medical Expenses Only
☐ Two or more clinic visits on non-duty time
☐ Clinic Visit(s) at Work After Injury/illness date
☐ Lost Time (enter number of days) _____
☐ Fatality

Description of Injury or Illness*

b. ADDITIONAL INDIVIDUAL - NAME

Employee Organization

Type (X one) ☐ Civilian Employee ☐ Foreign National ☐ Military

If Civilian Employee SSN:

CA 1 or CA 2 Filed ☐ Yes ☐ No

If Yes, Date (DD-MM-YYYY):

If Military Title

☐ On Duty ☐ Off Duty

If Foreign National ☐ Direct Hire ☐ Indirect Hire

Did inj/ill occur during Overtime? ☐ Yes ☐ No

Date Stopped Work or First Became Aware of Illness

Injury Case Classification (Check appropriate classification)

☐ Same Day Clinic visit or no treatment
☐ Medical Expenses Only
☐ Two or more clinic visits on non-duty time
☐ Clinic Visit(s) at Work After Injury/illness date
☐ Lost Time (enter number of days) _____
☐ Fatality

Description of Injury or Illness*

*Description Illness/injury: Identify the physical characteristics of the injury or illness and the parts of the body affected (i.e. sprained left wrist, cut index finger, fractured right arm; carpal tunnel syndrome affecting left wrist, use "multiple symptoms '', to describe symptoms such as abdominal pain, dizziness and headache, all of equal severity). For more than one body part, list each body part affected or use "multiple body parts''. Attach any additional information such as medical statements, pictures, other accident reports, etc., that pertain to this mishap.

INSTRUCTIONS FOR PAGE 1, BLOCK 5, MISHAP LOCATION: Provide the primary and secondary location of the accident site. Example 1 - At a depot, the primary location is the building and the secondary location is the area where the accident happened. Example 2 - For a car accident, name the street and closest cross street or other landmark to where the accident happened.

PRIVACY ACT STATEMENT

1. AUTHORITY: PL 91-596, The Occupational Safety and Health Act of 1 970 (OSHA), required each agency to "keep adequate records of all occupational accidents and illnesses for proper evaluation and necessary corrective action."

2. PRINCIPAL PURPOSE OR PURPOSES: Information is recorded and analyzed to identify the cause of the accident. Information may be combined with other accident data to determine agency-wide trends or cause factors. Non-personal data is collected to form the basis for statistical reporting to higher headquarters.

3. ROUTINE USES: The agency supervisors and managers use the information to determine actions required to correct the cause of the accident. The Safety and Health Managers use the information to insure actions proposed by supervisors and managers are adequate to prevent future accidents, to identify accident repeaters and safety award recipients, to provide verification that an accident occurred to personnel involved in processing workmen's compensation cases, to extract non-personal data to prepare statistical reports, accident summaries, and accident prevention information for inclusion in agency internal publications.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION: Disclosure is voluntary, however, the accident prevention effort will be seriously impaired if the information is withheld. There is no penalty for withholding information.

16. SUPERVISOR'S INFORMATION

a. NAME	b. ORGANIZATION	c. PHONE NUMBER (Cmcl and DSN)
d. SIGNATURE		e. DATE (DD-MM-YYYY)
f. COMMENTS/ACTION TAKEN TO PREVENT RECURRENCE		

17. REVIEWER'S INFORMATION

a. NAME	b. ORGANIZATION	c. PHONE NUMBER (Cmcl and DSN)
d. SIGNATURE		e. DATE (DD-MM-YYYY)
f. COMMENTS/ACTION TAKEN TO PREVENT RECURRENCE		

18. SAFETY AND HEALTH OFFICIAL/MONITOR'S INFORMATION

a. NAME	b. ORGANIZATION	c. PHONE NUMBER (Cmcl and DSN)
d. SIGNATURE		e. DATE (DD-MM-YYYY)
f. COMMENTS (Include SHIRS input date)		

19. COMMANDER'S INFORMATION PLFA ☐ SFLA ☐

a. NAME	b. ORGANIZATION	c. PHONE NUMBER (Cmcl and DSN)
d. SIGNATURE		e. DATE (DD-MM-YYYY)
f. COMMENTS		